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Housing First. The right to housing for the most vulnerable

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The *Housing First* model as a research or intervention approach in the homelessness field, focused on the people who have spent more than a year on the street and suffer severe mental health problems and/or addictions, has emerged as a social innovation. It was tried out for the first time in New York in the 90's, after the effectiveness of the traditional "staircase model" was called into question. It has also been implemented in Canada and Australia and been complemented with extensive evaluation work.

It's seen as a change of paradigm because, as opposed to the "staircase system", this approach starts at the end, providing permanent and self-contained housing. The right to housing and self-sufficiency is recognized. The attention is tailored to the needs, pace and options of the person. It's an intervention approach that must be co-produced from the principles of proximity, relationship, accompaniment and respect.

***Housing First* generates many expectations, but also questions, dilemmas and tensions in relation to both the implementation process and the analysis evaluations and research documented. Some of these questions and dilemmas will be addressed in this article.**

The field of attention to homeless people has been experiencing for more than ten years a small revolution, known as *Housing First*. At the start of the 90's, the clinical psychologist Sam Tsemberis launched a change of approach in the attention to the roofless people in New York, according to which permanent and self-contained housing was the start (and not the end) of the 'treatment' for mental illness. This model became federal regulation in the United States at the start of 2000 and was developed, with evaluations showing good results along with a cost-saving capacity, thus generating great interest in the academic and political field and in the media. It spread into Europe, becoming especially relevant after the European Consensus Conference on Homelessness held by FEANTSA (European Federation of National Organisations Working with the Homeless) in 2010. Since then, numerous European cities have launched experimental projects focused on this approach.

The diffusion of *Housing First* projects has caused some confusion regarding to terminology. The term is used to describe a very particular type of intervention with chronic roofless people suffering mental illness, and also for other interventions focused on other homelessness groups who share the principle of accessing independent, settled and guaranteed housing from the start. Likewise, other terms have also appeared, such as *housing-led*, *rapid re-housing, Pathways Housing First* and *housing first light,* among others.

In this article we will try, firstly, to clarify what's behind those terms. Secondly, we will assess the key elements of the "flagship" Housing First approach (known as *Pathways Housing First*). In third place, we will summarize some of the results. Finally, we will try to address some of the dilemmas that can be encountered when implementing this model.

1. Housing first without conditions

We will draw on homelessness approaches that stress two key factors. Firstly, that access to permanent and 'guaranteed' housing (with household security) is a first step in the solution to the homeless situation and is not the final step of a long path of previous interventions (staircase system). Secondly, that housing and retention are not conditioned to an acceptance to undergo treatment or to quit habits like drug or alcohol use. In other words, the house is not an incentive or a tool with which to pressure the person to accept or agree to other services he/she might need.

The most adequate term to refer to the diversity of programmes that share these two characteristics is *housing-led* (oriented or 'guided' by housing). This term was adopted in the 2010 Consensus Conference (ECCH 2011) named above. *Housing-led* includes programmes that can have various associated social or health intervention models (or none) and are addressed to a diverse homeless population. It must be pointed out that FEANTSA defines up to 13 forms and grades of homelessness and housing exclusion, grouped together in four big categories. Homelessness can also be chronic, short-term or even imminently threatened. Additional social, health or other problems can also be present.

As a general overview, and taking into account that definitions are used in different ways by various stakeholders, we can distinguish two broad types of *housing-led* programmes:

• Programmes targeted to chronic homeless people (more than a year without a home) with severe mental health problems or alcohol/drugs use. The most well-known model of this kind is the programme *Pathways Housing First,* that is faithful to the principles developed in New York by Sam Tsemberis. The term *Housing First* should be reserved for these types of programmes, but it is not so consistent in practice. A variety of this type of programme is called *Communal Housing First* (Pleace 2012) (congregated *Housing First* or in collective supported housing) and it offers independent and secure housing in buildings devoted to supported housing and not in scattered housing like *Pathways Housing First*. These programmes include an intensive support services offer that, as we will see later, can have diverse forms. This housing with intensive support is also called *supportive housing*, even though these types of programmes can be addressed to different homelessness situations.

• Programmes targeted to homeless people with lower needs or without social or health problems, covering from long-term homelessness to situations of risk (for example, threats of imminent eviction). These programmes can include a lower intensity support services array, or even not include any and refer cases where support is needed to the regular health provider in the area. Housing First Light (Pleace 2012) or Rapid Re-housing are examples of this second housing-led modality.

The rest of the article is devoted to analysing the first type of programmes, and we will use either *Pathways Housing First* or *Housing First* to discuss this topic.

2. How does *(Pathways) Housing First work*?

Housing First is an intervention approach for homeless people with serious personal, mental health and social difficulties that has the right to independent housing as its core element. It is based on the idea that having self-contained, dignified and adequate housing is the starting point and an intrinsic condition for a person to improve and recover, and not the result of a

process. Access to independent and settled housing is provided without prior conditions such as, for example, submitting to psychiatric treatment or quitting substance abuse, and professional support is offered, along with services tailored to the person's needs and according to their individual decision. It is underpinned by the principle that it's easier for a person to be in charge of his own life when he's in his own house than when he is on the street or in temporary accommodation centres (Gaetz et al 2013). Alongside this rapid and autonomous access to housing, *Housing First* is defined by high-intensity psychosocial intervention.

This model constitutes an innovation, a change of paradigm in the health and social attention to the most chronic homeless people. How does this approach work? What's the difference with respect to other modalities? Is it really more effective than others? What are the implementing costs? How does an intervention based on rights and person-recovery work? To what extent are changes produced when access to housing for very vulnerable people is facilitated?

Housing First starts at the "end"; that is, it provides access to stable housing as an element that can contribute to social inclusion (Moulaert et al 2013). This "reversal" of the ordinary intervention order is caused by questioning the efficiency of the 'traditional' models which correspond to the 'staircase system'. These are grounded on the principle that people must overcome diverse stages before being in a good condition to access self-contained housing, accepting as well an intervention plan. The staircase model considers that people with drug abuse or mental illness problems are not housing ready and need to follow a gradual process, step-by-step, towards housing inclusion.

The *Housing First* approach has generated expectations and supporters, especially with regards to the improvement of participants (also called users) and the reduction of institutionalization costs. Several doubts have emerged with respect to the improvement of social relations, as well as questions about how to put it into practice. It has also been criticised when presented as the sole response to end homelessness or when public funding is devoted to this type of model at the expense of others. We will now assess the definition and philosophy of the model, its principles and some critical questions identified in different application contexts (especially North America, Europe and Australia).

Origins of the model

Before the pioneer experience in New York, two projects with features similar to those of *Housing First* were developed. In Toronto, in the 70's, in the context of the closure of psychiatric centres and a deinstitutionalization process, the organisation *Houselink* promoted a project aimed at moving people discharged from centres with mental illness and drug abuse into housing. This project already considered housing as a right and recognised the person's capacity to make his own choice with the help of a support team. In Los Angeles in 1988 the programme *Beyond Shelter* used for the first time the concept *Housing First* to re-house homeless families, reducing thus the use of shelters and transitory housing (Waegemakers Schiff, & Rook 2012; Gaetz et al 2013). *Housing First* combines then the experience of forms of supporting housing, developed when people are discharged from psychiatric institutions, with its application "from the beginning" to roofless people.

The *Housing First* concept, as we have seen, became popular with the project *Pathways to Housing (PHF)*, seen as a pioneer and useful guide for many other projects. In 1992 the clinical psychologist Sam Tsemberis launched in New York a programme targeted to people with serious mental health problems and drug abuse from the organization *Pathways to Housing* (McCarroll 2002). It's based on the evidence that living on the street deteriorates mental health and that the staircase model hinders their social inclusion, mainly due to three factors:

- The individual stability process is basically linked to clinical stability, often separated from the person's surroundings.

- Users must go through a series of treatment phases attached to specific criteria and rules, which act as a barrier to treatment completion and housing access.
- Alcohol/drugs relapses, despite the fact they might have a therapeutic use, are penalised and can even lead to the person being dismissed from the programme.

Based on this evidence, Tsemberis proposed an attention model that starts at the end with access to housing, called *Housing First* (HF) (Tsemberis et al 2004).

Principles of the (Pathways) Housing First model

The *Pathways to Housing (PHF)* project originating from N.Y. proposed eight principles which have been used to evaluate the model's application in other countries. The principles for PHF and HF in Europe are the same, but formulated in a different manner. In the case of the Canadian project these principles are reduced to five, putting the emphasis on the participants' integration capacity, both in the community and his social surroundings. These five principles are listed below:

- Firstly, the **right to housing** as a human right that should be extended to any person and especially the most vulnerable, as is the case of homeless people. When housing is recognized as a right, it is not conditioned to treatment or any other type of requirement. Signing the contract with the landlord is a way of exercising this right. Housing is considered as a means to achieve stability and promote social inclusion (Tsemberis, & Eisenberg 2000; Jost et al 2010; Henwood et al 2011; McNaughton Nicholls, & Atherton 2011).

- Secondly, the *Housing First* model is a type of intervention focused on the **right to decide and person-centred.** The person must be able to exercise his/her **self-determination**. The individual must have the chance to choose with regards to housing, according to his needs (type of housing, area, etc.) in order to live the most autonomous way in self-contained housing integrated in the community. He must be able to choose the types and frequency of support services. For example, when the person wants to stop or reduce alcohol or drugs use or change medication because of the effects it has on them.

- Thirdly, this approach is steered to the **person's recovery**. Recovery is a concept increasingly in use in the mental health area, and differs from curing. There are various definitions. The US government agency for mental health and substance abuse defines recovery as a "process of change through which individuals work to improve their own health and wellbeing, and to live a sustainable life chosen by them within the community and try to develop their abilities as much as possible". It is, therefore, a process which is neither time-limited nor fixed to a specific goal. It is not defined by "where to get", but rather by in which direction to move forward. Each person 'recovers' in their own way and reaches 'better' situations, but they are different for each person as each has different capacities and limitations. Facilitating recovery means reducing prejudices against people with drug or mental health problems, and engaging with peers and within the community. Recovery is possible when the person has built trust and motivation to improve his wellbeing.
- Fourthly, **the person-centred approach acknowledges every person as different,** with his own needs. Some will need more intensive support and others will need limited or floating support. The support must be tailored to the autonomy of each person. Access to services or treatment has to be done on a voluntary and personal basis, adapted to his/her culture and when the person asks for it.

- Finally, this model seeks to **encourage people to become involved in the community and the society.** The access to services and activities is provided to encourage and maintain social relationships, educational, professional and leisure activities in the community he lives in or beyond it, according to his interests. (Tsemberis et al 2003; Tsemberis et al 2004; Stefancic, & Tsemberis 2007; Gaetz et al 2013).

Pathways to housing Estats Units	Housing First Europa	Housing First Canada
Housing as a fundamental human right	Housing First as a human right	Immediate access to permanent housing without housing readiness conditions
User respect. warmth and compassion		
Service user choice and self-determination	Service user choice and control	Individual choice and self-determination
	Commitment without coercion	
Services centered on the person's recovery	Recovery-based orientation	Emphasis on recovery
	Person-centered planning	Personalized support
A commitment to working with service users for as long as they need	Flexible support for as long as they need	
Separation of housing and treatment	Separation of housing and treatment	
Harm-reduction approach	Harm-reduction approach	
Scattered site housing using independent apartments		
		Social and community integration

Source: Own classification from Tsemberis 2012; Gaetz et al 2013 and http://housingfirstguide.eu.

In order to evaluate the model, the pioneer project PHF designed a fidelity evaluation tool, which has been used since then to assess the model's implementation and development (Greenwood et al 2013). With respect to research studies, the evaluation is external, made by a team of experts who know the model and validate it. The role of this team is to supervise and evaluate the process every six months. This validation is made through interviews to the different agents: managers, coordinators and professional teams, as well as 'peer workers' and participants in the project. At the end of every supervision the experts write a report and give feedback to the team in order to point out the specific elements which deviate from the principles and redirect the intervention so that it maintains fidelity towards the model using the outlined proposals (Greenwood et al 2013).

Design, planning and key elements of the intervention

The ultimate goal of *Housing First* is to achieve stability for the person in his housing, where he can feel better and recover, contributing to his social and community integration. This goal is connected to an action framework centred on the person and the recognition of rights, which are reclaimed through a fundamentally personal process.

Recognizing the right (not conditioned to treatment) to housing means renouncing a powerful external tool which could otherwise be used to motivate individual participation with treatment plans and to promote changes of habits. That implies that the person must be intrinsically motivated, according to his needs, interests and wishes.

This is one of the main differences from the staircase model, which is more centred on external motivations linked to conditions or compensations.

This form of action requires a certain proximity, which can only being achieved by being present, and an accompaniment where the knowledge of how to walk alongside a person and to remain between them and the services is crucial (Baillergeau et al 2009). Whenever possible, risk evaluation of substance abuse or mental illness should be done with the person. It's an acknowledgement practice consisting of listening and trusting the person's point, placing confidence in what they say in order to be able to recuperate his social place (Honneth 2006). It requires a positive view of the person, free of judgements regarding his/her behaviour.

In order to guide the action towards this goal, professionals must act as connectors and facilitators, serving as a bridge between services and the person so he/she can be attended respecting his rights. Housing First calls for a relationship and respect practice focused on restoring relationships of inequality and social exclusion, compensating and rebuilding integration deficits produced before. The intervention must be warm and respect the rhythm of the person in order to help him feel at ease when he returns to live in a home, to feel good again, to improve his physical, mental and emotional health and to continue on towards social and community integration.

The *Housing First* approach requires a programme of activities and services managed either by public or private institutions. Its philosophy and principles call for a global design able to incorporate all the range of support services and teams which will be involved. Some projects have two teams: one in charge of all intervention related to housing and another in charge of the psychosocial support and accompaniment. In other projects, the same team carries out both interventions.

Where teams work separately –yet in a coordinated manner– it's because housing and social intervention is complex and needs to be specialised.

In relation to the psychosocial intervention, teams must be able to cover the needs of the people who enter the programme with regards to their age, gender, cultural or ethnographic characteristics, as well as their physical, mental or social problems.

Some projects provide two modalities of treatment: one addressed to health problems or moderate addictions, and another to moderate problems and needs. They provide an attention model called *Intensive Case Management* and, for severe problems, *Assertive Community Treatment*. The main difference between these two models is that intensive case management is provided by a case manager who carries out the intervention and seeks other professionals if needed, while the assertive community treatment is based on a multi-faceted team able to offer all or the majority of interventions.

The Assertive Community Treatment team (TAC) is a multi-disciplinary team which tackles acute mental problems (schizophrenia, bipolar disorders, depression and severe personality disorder) and for that reason the intervention can’t be uniform and standard. Staff constantly evaluate risks and the attention to needs is usually complex. The user to staff ratio is lower than with other teams (between 8 and 10 people per team). One of the objectives of this team is to build a relationship of trust between the person and the team, as opposed to just one professional. All the team members agree and distribute the intervention tasks to be carried out. In order to clarify roles, staff are placed as ‘small teams’ managers or specialists in the clinical discussions with all the team (Gaetz et al 2013; Aubry et al 2015).

The case management and intensive case management teams (GC o GCI) are made up of staff with a different profile from the TAC, for example, social workers, physicians, specialists in human relationships, criminologist and occupational therapists. This team uses case management, consisting of one-to-one attention, where every professional is the case manager of a number of participants. The staff to user ratio is generally one case manager for 20 users. The intensity of the intervention will vary through time as the person finds stability and improves in different aspects of his life until reaching autonomy. The Canadian project *At Home/Chez Soi* demonstrated that, for a large number of participants, the first three months were the most difficult and the most intense support was needed at this stage to help their progress and recovery (Calgary Homeless Foundation 2011; Gaetz et al 2013).

Assertive Community Treatment	Intensive Case Management
A multi-disciplinary team of professionals offering all the services	One-on-one case manager to user relationship using a recovery-oriented approach
The team members are available 24/7 and provide real-time support.	Case managers are available during regular hours scheme and coverage is assured in coordination with other professionals;
Regular meetings with the team	The case manager negotiates the access to mainstream services according to the user's needs and options
The team is mobile. often meeting clients in their homes	The case manager often accompanies clients to meetings and appointments in support of their goals/ needs.
The staff to client ratio is generally 1 ACT team for 10 users	The staff to user ratio is generally 1 case manager for 20 users
Services are offered on a time-unlimited basis. with planned transfers to lower intensity services for stable clients.	The duration of the service is determined by the needs of the client. with the goal being the use of mainstream services as soon as possible.

Source: Own classification from (Gaetz et al 2013)

The peer worker's role

One of the new aspects of the *Housing First* approach is the role of the 'peer worker'. Peers are similar to the project's users, since they have lived in a homeless situation, they have a mental illness and/or they have been drug users. The intervention by these agents is based on the recognition of their proximity, learning and expertise gained on their recovery pathways, which can serve as a complementary tool to the professionals' technical and theoretical experience (Llobet Estany et al 2012).

Peer workers have practical skills, strength and capabilities they have developed in order to live and reach autonomy with their addictions and mental illness. These new agents join the teams and form a specific group in the project structure. Their role needs to be defined to fit with the project. Despite that, some projects confess they have needed time to adapt and negotiate this role. For that reason, it's important that they are a group. Their role is to provide the users' point of view in the analysis of different situations by the professionals: to welcome and speak with participants in order to defend their rights and encourage their individual and collective participation in relation to community services and resources.

3. Results

Housing First has been implemented in various cities in different countries such as the United States, Canada, Europe and Australia, with the same chronic homeless populations with mental illness and severe addiction problems, but it has also been used to provide solutions to other homeless groups or populations at risk of becoming homeless.

Research studies have been conducted to analyse comprehensively its impact, comparing a group attended with *Housing First* to another using mainstream services. Results demonstrate the efficiency of the first model and systematically revealed that it improves the situation of the people attended. Housing First minimizes their time on the street and reduces hospital admissions, problems with the courts and police and promotes stable housing occupation, and allows the person to choose a better place to live in than would be possible using regular services, programmes offering supervised housing for example. Data research shows that the model has improved users' health and quality of life and has reduced drug abuse and prompted social inclusion. Accordingly, one of the arguments for launching *Housing First* is the cost effectiveness for the community of the participants (Aubry et al 2014; Latimer et al 2014).

Evaluations effectively show that people attended by *Housing First* programmes use less often expensive services like psychiatric in-patient treatment, shelters and police or justice

proceedings. The cost savings in these services are very important. However, this argument needs to be treated with caution. Firstly, the savings vary greatly, depending on each person's characteristics. Research shows great differences between 'costs' generated by people with intensive needs and those by people with moderate needs.

Secondly, attention pathways can reduce the use (probably inadequate or unnecessary) of specific services and increase the use of others, which are necessary. That occurs with *Housing First* services for people with moderate needs, where referrals are made for support services which aren't provided directly. Thirdly, the period of time evaluated provides no evidence about long-term costs saving, which can be different from short-term ones.

In relation to costs, it must also be remarked that part of the savings are not directly recuperated (Latimer et al 2014). A reduction in hospital admissions or shelter services can release resources to attend other people, but it's highly unlikely that this results in a net reduction of expenses. A part of the costs 'saved' are assumed by other 'payers', different from those who assume the costs of the *Housing First* programme. A part of the previous attention costs were covered by sources such as private donations or contributions from organizations who provide the services. Another part of the costs doesn't 'exist' in reality when the person is not attended, or isn't attended by a formal service: a person who sleeps overnight on the street or at a friend's doesn't produce any cost, or at least he/she is not an expense for public services. Finally, according to the institutional configuration of each city, expenses for one local authority can become savings for another and not the one that is charged.

These results demonstrate that putting in place programmes where housing is seen as a right brings positive results, especially for the people who have spent a lot of time on the street and are suffering from serious problems, but the different research carried out doesn't prove that *Housing First* is the overall solution to homelessness. Homelessness causes are structural and require a systematic and multi-dimensional response. This approach is an opportunity to reduce the number of entrenched homeless, but structural factors, such as employment insecurity, the lack of sustainable social policies providing some sort of income for the most vulnerable or the lack of affordable social rent expose new people to the street.
The attention to the diverse situations of homeless people demands a multi-faceted approach, such as *Rapid Rehousing* in the case of people who have been on the street a short time or *Housing First* with different intensities of support according to the person's needs.

4. Some dilemmas and key questions to develop Housing First

The *Housing First* model generates many expectations. In people who can't quite believe housing access can be possible without prior conditions or housing readiness. In policy-makers and experts as research evidence encourages them to think it can be a more effective and cost-effective model than the models being applied until now, especially when dealing with a population group defined as chronic and for whom recovery is very difficult. In organizations and professionals, since it means an opportunity to explore other organizational and intervention forms based on "believing in the person" in severe social exclusion situations. It's an approach that tends to be clear from a theoretical point of view, but is challenging to put into practice. This challenge contains difficulties, risks, limits and tensions that should be identified. There's a large bibliography on the topic, but there's little information about the model's intervention and practice.

A. Implementation challenges and organization

Launching a project inspired by the Housing First model doesn't necessarily mean applying the same type of programme run by the pioneer organizations when it was first implemented –first *Pathways to Housing* in New York and later *Street to Homes* in Toronto. The projects are inspired by others that already exist, but at the same time they adapt to each context's specific features.

The complexity of the project and the implication of different public and private organizations and those related to the third sector demand a definition of the management structure, to be able to plan, design and implement the model. This structure will need readjusting when unexpected factors emerge, since some phases are especially complicated and the project might also provoke criticism and tension.

Different committees, councils or focus groups can form this structure.

It's important to clarify the term of each council and/or committee, its organization and functions, the actors who form it and the regularity of the operative sessions. The Committee is in charge of the strategic and operative management of the project. The Integration Committee is in charge of the running and the connection with the teams and reaches agreements when faced with new situations or problems, such as the non-payment of housing, the participants' access to housing, the impact of the rhythm and regularity of this access on the teams, the teams' roles, etc. The project's implementation provokes reactions in the services for homelessness, mental health and drugs addiction, as well as housing. The Committee integrated by agents of these areas can act as a feedback tool between the agents and the project. Therefore, the project can be addressed in a wider context, contributing to set a joint vision of the services geared to the homeless population according to the different areas and evaluating as well the community interest regarding the project. A collaborating and evaluating posture can be fomented between the actors which are not directly linked to the project who, on one side can see the project as an opportunity, but at the same time question the consequences it can have on public funding once it's finished. People who have lived in a homeless situation and have used the services form the Council of peer workers. Their role is to represent the individual's point of view, welcoming participants to the project, getting involved and encouraging them, activating collective citizen participation in order to defend rights and individual participation.

The members of this committee also participate on other councils or committees.

The *Housing First* option from the political perspective must be accompanied by the presentation of results in economic terms, but above all in human and social policies terms that can improve the life of a sector of the population that appeared to be deprived of resources. The implementation demands available resources, a readjustment and a shift from the support areas for this population –local authorities, services, community, professionals and participants in the project.

The homelessness phenomenon needs a systemic approach and *Housing First* is one more programme with a philosophy and principles that have been applied in different ways and in diverse contexts that have produced different models. The results are encouraging, provide a conception shift based on the recognition of rights in extreme exclusion situations –housing situations, among others– and provide many ideas that can dramatically improve intervention and services, although, as of today and according to the research and literature, it's risky to present this model as the solution to homelessness.

B. Design and intervention challenges

Housing First requires an intervention with new components that can have difficulties at the time of putting the model into practice in our context. In this section, we will detect some of these elements along with proposals to develop them.

Firstly, we have no precedents of this practice in our context. Accordingly, the projects launched under the Housing First model will have an experimental character and should be attached to an investigation programme, as has been done in other cities, in order to collect data and evaluate the model's usage in our context. It is especially recommendable if the

model is to be extended and/or a global review of the intervention system in homelessness carried out.

Secondly, the intervention centred on the subject as a rights bearer requires a system tailored to the person and not the other way round, as usually happens with other intervention models. This model makes us reconsider all the system from different areas, devices and professionals. At the time of re-evaluating the model, the view of the people who know the services and the attention circuit must be taken into account. It implies a culture shift amongst organizations and professionals which is not easy to imagine. On the other hand, the social citizenship and social rights in every context condition the practice. Regarding the Spanish State, the social rights of citizens when dealing with a lack of income or social support needs are limited and fragmented (Laparra Navarro, & Aguilar Hendrickson 1996; Laparra Navarro 2004; Laparra Navarro et al. 2009).

Direct social attention is still influenced by the old public welfare network, according to which the person who has no means of survival has no rights, in a strong sense of the word. People with difficulties report their situation and the local authority has the moral right to attend them, but with the person in an inferior position and the State acting as protector (Aguilar Hendrickson 2010). It is more about a relationship based on humanitarian help, than a citizenship right. Even though the moralistic and paternalist character of these practices has been reduced, the lack of a relationship full of rights has maintained part of this tutelary conception. Housing First means to change from this tutelary conception, still very much alive in organizations and interventions, to a civil rights conception. On the other hand, people have learnt to adapt to an intervention model of ‘staircase transition’, where housing is not a subjective right and therefore they rarely expect and even less demand this right.

Action plans must be reoriented with adequate mechanisms in order to detect and overcome these obstacles. Organizations and professionals must share and integrate values and model principles not only in theory, but also during the intervention. Previous training with real cases can enable this knowledge to be obtained. Cases can be analysed from a clinical and psychosocial perspective in supervision and coordination areas, detecting that way dilemmas, questions and doubts about the practice. Professionals will face situations they must learn to assess in a different way to that which they are accustomed. It's a practice which requires the deconstruction of some of the notions and mechanisms learnt during previous interventions. The coordinator becomes a key figure when tackling difficult or critical situations on a daily basis and teamwork is another integral part of the approach. If having professionals from different fields in the same team is a challenge, having professionals from different operational areas and cultures is even more challenging. Professionals must make team decisions based on knowledge and in a horizontal way, reducing hierarchical powers. This practice based on interaction requires a lot of insight (Schön, & Bayo 1998). For that reason, it's suggested to create a community of practice among professionals to be able to share knowledge and tools gained through first-hand experience. When the practice has an experimental character as in this case, intervention can be a space for self-knowledge, self-training and reflection.
This type of practice forces professionals, who find themselves working much closer with the person, to put their position and power into question, especially when they have to deal with disconcerting situations, as they have to respond in a different way from that which they were used to. It requires very committed professionals who have clear which values to defend and feel motivated to explore and co-produce an uncertain practice which relies on the person’s will, stimulates creativity and demands flexibility and a lot of humility. Professionals must be able to accept the relationship's limits and turn to someone, in this case the coordinator, to identify their own limits and difficulties. The team must look after its own mental health and wellbeing by creating common spaces for that purpose.

C. Challenges of combining social support and housing policies

The development of *Housing-led (Housing First* and others) initiatives and projects reveal some of the general questions about policies to tackle residential exclusion and the interplay of housing policies, social policies and health services. In this last chapter we will attempt to formulate some of these challenges and any possible development path.

The first problem is to know the range *housing-led* policies can have. Focusing on tiny groups which have used them allows us to obtain, according to known experience, very positive outcomes for the cases attended. On the other hand, they face two important risks: firstly, having limited effect over the global extent of homelessness and housing exclusion, and secondly, in contexts where housing access is difficult for large sectors of the population they can cause perceptions of unfair disadvantages which might erode the legitimacy of these policies. Multiplying efforts in the attention of people who suffer most complex difficulties promotes fairness when the majority of the population has enough support (usually less intense) for their basic needs.

Recent research (Colombo 2016) points out housing market context as a relevant factor. *Housing-led* projects seem to have good perspectives as a framework in the fight against housing exclusion in cities like Vienna (80% of housing is rented, 25% public renting) and are seriously hindered in cities like Budapest, London and Stockholm, with much more difficult housing markets.

A second important question is how to connect housing policies with social support policies and guaranteed income. *Housing First* projects have been broadly developed from social service fields and their continuity, beyond the time limits of the projects, depends largely upon guaranteed income provision (minimum income, rental allowances) and/or 'guaranteed' access to housing (public housing).

Beyond the continuity of the projects, an opportunity is available to review the relationship between social services and social housing. There are a wide range of situations where people need simultaneous personal, social or health support (usually combined) and housing (sometimes adapted). Housing First projects are an example, but there are others such as re-housing for eviction causes (emergency housing) or in cases of domestic violence, supported housing for people with dependency needs (from home visits to homes or residences with supported services or housing with service facilities on-site) and other types of supported housing. These types of interventions lack a clear and definitive action plan regarding the roles of public access to housing and social and health services. *Housing First* projects which are launched in Barcelona might be a good occasion to address this question.

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